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New STD treatment guidelines published

The Centers for Disease Control and Prevention (CDC) released new sexually transmitted disease (STD) treatment guidelines in May 2002, adding California to the list of areas where fluoroquinolones should not be used as a first-line therapy to treat gonorrhea.

The recommendation stems from antimicrobial resistance surveillance in California, which has demonstrated a prevalence of ciprofloxacin-resistance gonorrhea of nearly five percent (5%) in the second half of 2001 and nearly seven percent (7%) in the first quarter of 2002. Prior to this time period, the level of ciprofloxacin resistance in California was considered low, ranging from 0.2 percent in 1998 to 1.1 percent in 2000, according to data from the national Gonococcal Isolate Surveillance Project (GISP). Orange County is one of four sites in California participating in the GISP.

The new sexually transmitted disease treatment guidelines can be reviewed on the CDC website at www.cdc.gov/std. The new recommendations update the 1998 Guidelines for Treatment of Sexually Transmitted Diseases and were developed by CDC after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta on September 26–28, 2000.

Other recommendations of the CDC's new STD treatment guidelines include:

Chlamydia screening

In keeping with other recommendations, sexually active adolescent females 19 years old

and under, and young adult women 20 to 24 years old, should be screened annually, even if symptoms are not present. Older women with a risk factor for chlamydia, such as a new partner or multiple sexual partners, also should be screened annually. Also, health care providers are now advised to re-screen all women who are diagnosed with chlamydia three to four months after they complete initial treatment.

STD Screening for men

The CDC is recommending that providers assess the gender of partners among male patients. For their gay and bisexual patients, health care providers are urged to annually screen for chlamydia, syphilis, and gonorrhea. These patients should also be screened for HIV if they are uninfected or if their status is unknown.

Providers should encourage their patients to be vaccinated against hepatitis A and B. More frequent screening may be necessary for those

who have multiple anonymous partners and those who have sex in conjunction with illicit drug use.

Risk assessment and counseling

CDC's new guidelines encourage health care providers to focus on risk assessment and counseling, in addition to the clinical aspects (screening and treatment) of STD control. To assist providers with their prevention efforts, the clinical prevention guidelines have been expanded for 2002. Providers are encouraged to use health education approaches tailored for each of their patients. To avoid the spread of STDs, the guidelines suggest that patients should abstain from oral, vaginal and anal sex. Patients who are sexually active should be counseled to be in a mutually monogamous relationship with an uninfected partner or use a condom during each sexual act.

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Baylisascaris procyonis—raccoon roundworm

Epidemiology

Since 1998 at least 3 cases of raccoon roundworm (*Baylisascaris procyonis*) encephalitis have been reported in California. At least 12 cases have been diagnosed in the United States since 1980—4 were fatal and the others had serious sequelae. The incidence of infection in humans is probably underrecognized.

B. procyonis is a common (70% to 90%), asymptomatic infection of raccoons. Huge numbers of eggs are excreted from the intestines of infected raccoons—as many as 45,000,000 per day. Eggs develop externally, usually in soil, for 2–4 weeks and are then infectious. Humans are infected when they ingest infective eggs. These eggs mature into larvae, which migrate to tissues, especially the nervous system where they can cause eosinophilic encephalitis (neural larva migrans) and/or ocular disease (ocular larva migrans). Eosinophilic cardiac

pseudotumor can also occur. Infection is most common in younger age groups, particularly infants, because of their oral exploration of the environment.

The most recently reported case occurred in April 2002 in an eleven-month-old male from Santa Barbara County. The child, who most likely contracted the infection at a day care center, survived but suffered severe neurological deficits, including blindness, despite treatment with decadron and albendazole. Testing confirmed the presence of *B. procyonis* eggs at the day care center, where remediation included an extensive clean-up of the outside play area.

Diagnosis

A diagnosis of *B. procyonis* encephalitis should be considered if there was sudden onset of eosinophilic encephalitis and a history of potential exposure. CSF eosinophilic pleocytosis

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**DISEASE REPORTING
REQUIREMENTS 2**

**NEW BREAST AND CERVICAL CANCER
TREATMENT PROGRAM 3**

STD's (Continued from Page 1)**The Use of Nonoxonyl-9 (N-9)**

Recent studies have found that frequent use of N-9, a spermicide contraceptive, can cause genital lesions (in the vagina) and, therefore, may increase the risk of HIV transmission. It has also been found to cause damage to the lining of the rectum, providing an entry point for

HIV and other STDs. Spermicides alone are not recommended for STD/HIV prevention and N-9 containing spermicides and lubricants are not recommended.

Serologic Herpes Testing

CDC is recommending the use of new serological tests that can help providers with diagnosing and managing genital herpes by

determining if a patient is infected with herpes simplex type one or type two. The majority of individuals with recurring genital outbreaks are infected with HSV-2 and may benefit from either suppressive antiviral treatment, which may prevent outbreaks, or episodic treatment, which can shorten the duration of outbreaks.

New California gonorrhea treatment guidelines

In response to the increase in fluoroquinolone-resistant gonorrhea in California, the California Department of Health Services, Sexually Transmitted Diseases (STD) Control Branch, and the California STD Controllers Association have issued the following treatment recommendations:

- Avoid the use of fluoroquinolones (ciprofloxacin, ofloxacin, and levofloxacin) to treat gonorrhea in California.
- Antibiotics of choice to treat uncomplicated gonococcal infections of the cervix, urethra, and rectum include:
 - ▲ **Ceftriaxone** 125 mg intramuscularly in a single dose
OR
 - ▲ **Cefixime** 400 mg orally in a single dose.
- Alternative antibiotic regimens for the treatment of uncomplicated gonococcal infections of the cervix, urethra, and rectum include:
 - ▲ **Spectinomycin** 2 g intramuscularly in a single dose
OR
 - ▲ Single-dose injectable cephalosporins: **Ceftizoxime** 500 mg IM, **Cefoxitin** 2 g IM with **Probenecid** 1 g orally, or **Cefotaxime** 500 mg IM.
- The antibiotic of choice to treat gonococcal infections of the pharynx:
 - ▲ **Ceftriaxone** 125 mg intramuscularly in a single dose.
 - ▲ Cefixime is not recommended by the CDC to treat pharyngeal infections because of a relative lack of published data demonstrating efficacy. However, providers may choose to use cefixime because of the ease of oral administration. If cefixime is used to treat pharyngeal infection, a test-of-cure is recommended.
- For patients with significant anaphylaxis-type (IgE-mediated) allergies to penicillin, where the use of cephalosporins is a concern or for patients with allergies to cephalosporins:
 - ▲ **Spectinomycin** 2 g intramuscularly in a single dose
OR
 - ▲ Fluoroquinolone with test-of-cure¹
OR
 - ▲ **Azithromycin** 2 g orally in a single dose with test-of-cure¹.
- For the treatment of pelvic inflammatory disease (PID), the CDC guidelines should be followed. However, if the gonorrhea test is positive in a patient receiving a fluoroquinolone regimen, a test-of-cure¹ should be performed.
- Co-treatment of chlamydia in patients with gonorrhea is still recommended unless chlamydia infection has been ruled out using sensitive test technology (e.g., nucleic acid amplification test, or NAATs). Recommended antibiotics for the treatment of chlamydial infection include:
 - ▲ **Azithromycin** (1 g orally in a single dose)
OR
 - ▲ **Doxycycline** (100 mg orally twice a day for 7 days).

Clinicians need to be alert to the failure of any patient to respond to recommended therapy. If clinicians encounter a treatment failure after a recommended regimen in the absence of reexposure, they need to take whatever steps are necessary to culture the organism.

¹Ideally, the test-of-cure should be a culture test so that the isolate can be tested for antimicrobial susceptibility and a nucleic acid amplification test to maximize sensitivity. If only a non-culture test is used, positive results should be followed up with a culture and susceptibility testing before the patient receives an alternative treatment.

State reportable disease requirements updated

The California Department of Health Services has approved emergency regulations to update the list of reportable diseases, adding two new diseases/conditions to the list of diseases that must be reported by health care providers to the local health officer.

The emergency regulations return smallpox to the list of reportable diseases, requiring that cases or suspected cases of smallpox be immediately reported by telephone to the local health officer. The same immediate reporting requirement also now applies to varicella (deaths only) as a way to enhance the detection of possible smallpox cases. Another major change in the disease reporting requirements is making bru-

cellosis, tularemia and occurrences of any unusual disease immediately reportable by telephone. The previous reporting requirement for these conditions was within seven days.

The section of the California Code of Regulations dealing with reportable diseases underwent its last major revision in 1996 to address newly recognized emerging and reemerging infectious diseases. The latest revisions are in recognition of the potential threat of bioterrorism attacks against the United States and are part of a nationwide effort to make certain diseases and conditions reportable on a uniform basis as part of an upgraded disease surveillance system. The changes recognize that before effective public health action can be

taken against a deliberately introduced disease outbreak, cases must be recognized by frontline health care providers and be reported as soon as possible to the local health officer. It is important to note these requirements apply to all cases of the reportable diseases, not just those the provider may believe to be bioterrorism related.

A current list of reportable diseases is included as an insert to this edition of the Public Health Bulletin and is available on line at www.oc.ca.gov/hca/docs/forms/diseases.pdf. For local assistance in determining disease reporting requirements, please contact the Orange County Health Care Agency's Public Health Epidemiology and Assessment Program at (714) 834-8180.

New breast and cervical cancer treatment program

A new state program providing treatment for low-income, uninsured and underinsured California residents diagnosed with breast or cervical cancer took effect January 1, 2002. The Breast and Cervical Cancer Treatment Program (BCCTP) was created by Assembly Bill 430, which was signed by the Governor on August 9, 2001. BCCTP is partially funded by federal dollars under the Breast and Cervical Cancer Prevention and Treatment Act of 2000. The Program has two parts: a federal/state option and a state-only option with different eligibility requirements.

Federal/State Option

This option provides full-scope, no-cost, Medi-Cal for those individuals screened and diagnosed with breast or cervical cancer by a Breast Cancer Early Detection Program (BCEDP), Breast and Cervical Cancer Control Program (BCCCP) or Family PACPT (F-PACT) provider. Individuals must be under age 65 and not currently enrolled in Medicare, Medi-Cal or another form of healthcare coverage.

State-Only Option

The state-only option covers low-income,

uninsured individuals age 65 and older and those who are undocumented. In addition, those individuals whose annual insurance co-pays, premiums and deductibles exceed \$750 are eligible to have the state cover the co-pays, premiums and deductibles necessary to access cancer treatment. The state also pays for breast or cervical cancer treatment not covered by their insurance.

Patient Enrollment

The California Department of Health Services (DHS) determines eligibility of applicants. BCEDP, BCCCP and F-PACT providers can enroll patients through an Internet-based application system found at www.medi-cal.ca.gov.

1. Click on "Transaction Services"
2. Enter a valid provider number and PIN
3. Select BCCTP icon

Once the information is entered into the system, a printable confirmation of eligibility is generated and a copy must be given to the applicant. If the confirmation document indicates eligibility, the applicant may use the confirmation document for immediate access to medical services until the applicant receives a Benefits Identification Card (BIC). The enrolling provider

will then mail the application and the Rights and Responsibilities form, each with the applicant's original signature, to DHS. DHS eligibility specialists review each Internet-based application form to complete the determination of BCCTP eligibility. The specialist may require additional information from the applicant to determine eligibility.

Healthcare Provider Enrollment

BCEDP, BCCCP and F-PACT providers will be BCCTP enrolling providers, responsible for completing the Internet-based application for other providers, should call 1-800-824-0088. Please leave your name, address and telephone number with a DHS Eligibility Specialist to be placed on the BCCTP referral list. When a non-enrolling provider or an applicant calls to locate an enrolling provider, they will be referred to an enrolling BCCCP, BCEDP or F-PACT provider. For providers who are not an authorized, enrolling BCCTP provider, please refer the patient to an authorized, enrolling provider. For referrals to authorized, enrolling BCCTP providers, please call the BCCTP at 1-800-824-0088.

Roundworm (Continued from Page 1)

sis, peripheral eosinophilia, deep white matter abnormalities on MRI, positive titers on serologic testing of CSF and serum (not available commercially) and exclusion of other causes are suggestive of the diagnosis. Examination of tissue biopsies can be extremely helpful if a section of larva is contained, but removing an appropriate piece of tissue where the larva is actually present can be problematic, and identification of *B. procyonis* is difficult. Ocular examinations revealing a migrating larva, larval tracks, or lesions consistent with a nematode larva are often the most significant clue to infection with *Baylisascaris*. Autopsy can provide definitive diagnosis.

Treatment

There is no effective treatment for *B. procyonis* infection. Laser photocoagulation may be successful in ocular infection.

Prevention

- Avoid direct contact with raccoons, especially their feces. Do not keep, feed, or adopt raccoons as pets.
- Discourage raccoons from living in and around homes and parks by removing access to food. Clear brush so raccoons are not likely to make a den on the property. Cover

sandboxes when not in use to discourage animals from defecating in these areas.

- Stay away from areas and materials that might be contaminated by raccoon feces. Raccoons typically defecate at the base of or in raised forks of trees, or on raised horizontal surfaces such as fallen logs, stumps, or large rocks. Raccoon feces also can be found on woodpiles, decks, rooftops, and in attics, garages, and haylofts. Feces usually are dark and tubular, have a pungent odor (usually worse than dog or cat feces), and often contain undigested seeds or other food items.
- Promptly remove fresh raccoon feces; newly deposited *B. procyonis* eggs take at least 2-4 weeks to become infective. Care should be taken to avoid contaminating hands and clothes when removing the feces.

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<http://www.cdc.gov/ncidod/EID/vol8no4/01-0273.htm>



Photo of embryonated *Baylisascaris procyonis* egg (50 microns in length)

CDC fact sheet

<http://www.cdc.gov/ncidod/dpd/parasites/baylisascaris/>

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First Quarter (Weeks 1-13)				
Number of Cases by Year of Report				
DISEASE	2002	2001	2000	1999
AIDS	53	92	76	70
AMEBIASIS	3	5	6	5
CAMPYLOBACTERIOSIS	52	59	47	42
CHLAMYDIA	1526	1129	948	1342
CRYPTOSPORIDIOSIS	4	3	0	1
E-COLI O157:H7	0	0	0	2
FOOD POISONING OUTBREAKS	19	3	1	6
GIARDIASIS	36	47	62	46
GONOCOCCAL INFECTION	212	119	116	154
H-FLU, INVASIVE DISEASE	1	1	0	3
HANSEN'S DISEASE (LEPROSY)	0	0	0	0
HEPATITIS A (acute)	30	48	62	54
HEPATITIS B (acute)	11	12	19	16
HEPATITIS B (chronic)	335	406	446	392
HEPATITIS C (acute)	0	1	0	5
HEPATITIS C (chronic)	347	622	589	549
HEPATITIS OTHER/UNSPECIFIED	5	1	13	2
KAWASAKI DISEASE	3	3	2	4
LISTERIOSIS	5	4	3	3
MALARIA	4	3	5	0
MEASLES (RUBEOLA)	2	4	0	0
MENINGITIS, TOTAL	64	39	64	60
ASEPTIC MENINGITIS	47	28	39	36
MENINGOCOCCAL INFECTIONS	2	6	12	7
MUMPS	4	1	0	1
NON-GONOCOCCAL URETHRITIS	220	152	141	144
PERTUSSIS	26	3	7	7
PELVIC INFLAMMATORY DISEASE	17	9	8	2
RUBELLA	0	0	0	0
SALMONELLOSIS	54	51	76	68
SHIGELLOSIS	27	12	76	34
STREP, INVASIVE GROUP A	24	10	18	13
SYPHILIS, TOTAL	74	55	60	51
PRIMARY	4	5	2	2
SECONDARY	2	8	3	3
EARLY LATENT	6	7	4	1
LATENT	1	4	1	0
LATE LATENT	61	31	42	44
CONGENITAL	0	0	8	0
NEUROLOGICAL	0	0	0	1
TUBERCULOSIS	15	37	29	42
TYPHOID FEVER, CASE	1	0	0	0

County of Orange Health Care Agency

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